DoD Medical Examination Review Board
8034 Edgerton Drive, Suite 132
USAF Academy, Colorado 80840-2200

ALLERGIES QUESTIONNAIRE

NAME: _____ SOCIAL SECURITY NUMBER: _____-_____-_____

Please complete all of the questions below regarding history of allergies and return this form to DoDMERB at the above address: If more space is needed, please use back of form and identify each issue by question number.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397
PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).
ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1) Please list your allergies (e.g., allergic rhinitis, hayfever, foods, insects, etc.)? _____

2) Please list current treatment and/or medication used for your allergies (frequency and duration): _____

3) Do you experience any complications from your allergies? YES NO If yes, please explain (e.g., sinusitis, ear blocks, nasal polyps, rash/hives, breathing problems, swelling/tingling, etc.): _____

4) Have you ever had asthma, reactive airway disease, exercise induced bronchospasm, or wheezing?
YES NO If yes, please answer 4a, 4b, 4c, and 4d below:

4a) Age of onset: _____ **4b)** Date of last symptoms: _____ **4c)** Date of last medication/treatment: _____

4d) Treatment and/or medication(s)/name and frequency: (daily, weekly, prior to athletic/recreational activities, as needed):

5) Have you ever been treated for shortness of breath? YES NO If yes, please explain:_____

6) Have you ever had any past or present skin problems? (e.g., eczema, atopic dermatitis, hives, or urticaria, etc.): YES NO
If yes, please answer 6a, 6b, 6c, and 6d below:

6a) Age of onset: _____ **6b)** Date of last symptoms: _____ **5c)** Date of last medication/treatment: _____

6d) Treatment and/or medication(s)/name and frequency: (daily, weekly, as needed):_____

7) Describe any contact allergies, (e.g., latex, wool, chemicals, etc.) symptoms, treatment and/or medication(s) and date(s):

8) Have you ever had any reaction(s) to food(s)? YES NO **If yes, list food(s) and related symptoms in detail:**

9) Certification: By signing below, I hereby certify that the above information is true and accurate to the best of my knowledge.

_____ _____
Applicant's Signature Date